Certification Standards

For

Centers of Excellence

June 23, 2016

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I. PROGRAM OVERVIEW

A. Introduction

These certification standards are issued by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). This document provides guidance to interested parties who may choose to apply for certification to become recognized as Centers of Excellence (COE) in the treatment of opioid use disorders. BHDDH reserves the right to amend these standards at any time, giving reasonable notice to providers about changes affecting their operations.

Through the work of the Governor's Opioid Overdose Prevention and Intervention Task Force, BHDDH has identified COEs for the treatment of opioid use disorders as those providers that will be certified by meeting these certification standards and that will then be reimbursed by the Medicaid Program. A COE is a specialty center that utilizes evidence-based practices and is responsible for providing treatment to and coordinating the care of individuals with moderate to severe opioid use disorder. The goal is to ensure timely access to appropriate, high quality Medication Assisted Treatment (MAT) for individuals diagnosed with opioid use disorder.

This initiative will ensure that MAT is available to all Rhode Islanders who are Medicaid eligible. COEs are intended to expand and enhance the statewide capacity for MAT, increasing accessibility, not only in COEs, but through community providers, improving the quality of care and patient satisfaction.

COEs will provide assessments and treatment for opioid dependence, will offer expedited access to care, and serve as a resource to community based providers. Research indicates that follow through with treatment is increased when services are available immediately. To increase successful referrals, BHDDH is creating two (2) levels for COEs based on ability to conduct expedited admissions. Level 1 providers will be able to admit all individuals within twenty-four (24) hours of referral and will receive an enhanced rate for induction as this will require physician availability seven (7) days per week. Level 2 providers will be required to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday.

A multi-disciplinary staff, including peer professionals, will work together to provide patient-centered care that addresses all of an individual's treatment needs. Since the effective treatment of opioid use disorders includes the use of FDA-approved medications (methadone, buprenorphine products and naltrexone), COEs will be able to provide medication services onsite. The COEs will use qualified physicians familiar with the use of these medications and who are waivered to prescribe buprenorphine.

Individualized care will include a range of treatment options. COEs should also make patient-focused programs and services available. These ancillary services which assist patients in recovery include individual and group therapy, help with obtaining other needed health services, social services, and recovery/remission supports such as peer professionals. Peer professionals are peer

recovery specialists who have lived with mental illness and/or substance use disorders and have completed formal training to provide one-on-one strength-based support to individuals in recovery.

Other features of COEs will include comprehensive patient and family education programs; quality metrics to examine patient outcomes and to improve services; timely access to care with minimal waiting lists and support resources for patients who have been referred into the community. The goal of the COE is to provide intensive services to individuals needing to stabilize on medication and begin the recovery process. Once stable, patients will be referred to community based providers, but still have the opportunity to maintain connections to clinical or recovery support services offered by the COE. Once referred to the community, patients who need more intensive services, perhaps due to relapse or crisis, will have the opportunity for immediate readmission to the COE. The COEs will also have the ability to provide on-site training for physicians and other professionals.

Referrals to COEs can be made by anyone from the community to a certified provider. It is anticipated that a majority of referrals will be made by Emergency Departments throughout the state treating opioid overdose survivors. All certified COEs will be required to establish clear referral pathways to ensure smooth transitions of care. Through this document, BHDDH is issuing Certification Standards for all COEs which include: program requirements, service descriptions, staff qualifications, eligibility requirements, and performance standards.

B. Background

Addiction and overdose are claiming lives, destroying families, and undermining the quality of life across Rhode Island. In 2014, 239 people in our state lost their lives to overdose, more than the number of homicides, motor vehicle accidents, and suicides combined. In 2015, the RI Opioid Overdose Prevention and Intervention Task Force was created to propose a strategic plan that puts forth the most impactful initiatives in the areas of prevention of opioid addiction, reversal of opioid overdose, treatment of opioid addiction, and recovery to reduce addiction and stop overdose death in Rhode Island. This is a strategic plan whose goal is to complement existing overdose prevention efforts to achieve the most immediate impact on addiction and overdose.

Opioid use disorder (referred to sometimes as opioid dependence and addiction) is a chronic relapsing disease that can develop with repeated exposure to opioids. There are strong genetic, situational, and societal factors that increase the risk of developing opioid use disorder. Untreated, it can be deadly. Opioid addiction is characterized by the development of tolerance (the need for an increasingly higher dose to achieve the same effect), and withdrawal (a painful condition that occurs when people try to reduce or stop use abruptly). Fortunately, treatment for opioid addiction is effective and long-term recovery is possible.

For over a decade, opioid dependence and accidental drug overdose have been growing problems across the United States, and Rhode Island has been one of the states hardest hit. In 2013, Rhode Island had the highest rates of illicit drug use in the nation, as well as the highest rate of drug overdose in New England.

This recent increase is proportional to a dramatic increase in the amount of opioids prescribed. The result has been the creation of a generation of people addicted to opioids. Many individuals typically begin with opioid pain medications—such as hydrocodone (e.g. Vicodin, Lortab, Norco), and oxycodone (e.g. Percocet, OxyContin)—and, often for economic reasons, transition to heroin use, and injection drug use. Since 2002, rates of heroin addiction have doubled and heroin-related overdose deaths have nearly quadrupled in the United States. Adding to these challenges, benzodiazepines have become increasingly available which, when taken with opioids, substantially increase the risk of overdose. Finally, overdoses related to fentanyl-laced, illicit drugs have increased dramatically across the US.

Several recent shifts in overdose trends are important to note.

- 80% of overdose deaths in 2015 were illicit drug involved, up from 67-70% in prior years. Death rates for 2014-2015 are high in Providence and in many surrounding towns and cities; for instance, in Warren, Central Falls, and southwestern Rhode Island. With the exception of only four towns, all municipalities reporting opioid-associated overdoses also reported fentanyl involved overdoses.

- 50% of overdose deaths in 2015 involved fentanyl, up from 37% in 2014, and far higher than prior years, where less than 5% of deaths involved fentanyl. Locations of fentanyl-involved deaths are not concentrated geographically. Fatal fentanyl-involved overdoses are more common among men, young people, and persons using by injection. 37% of fentanyl-involved overdose decedents in 2015 had recently been in prison or jail, up from 19% in 2014.

Outreach for earlier engagement in treatment with evidence-based medical therapies and long-term recovery supports for people with opioid use disorder—in addition to broader public health, public policy, and societal changes—has the potential to have a significant beneficial effect.

Evidence indicates that MAT (methadone, buprenorphine or injectable- naltrexone* injection) has profound effects on people with an opioid use disorder. It reduces their risk of death, relapse, chance of going to prison, and greatly improves their quality of life. MAT is most effective as a long-term treatment. Making MAT as available as possible, whenever possible, can save lives.

In 2015, there were 4,500 individuals receiving treatment with methadone in Rhode Island and 4,662 individuals were treated with buprenorphine under the care of a physician, although many just for medical withdrawal (also called ‘detoxification’). Methadone availability is widespread in Rhode Island, with many programs and capacity to expand, and generally no or very short waiting lists. Buprenorphine availability is far more scarce. Currently, the opioid treatment programs do not dispense buprenorphine. In 2015, fewer than 75 physicians were Drug Abuse Treatment Act (DATA) waivered (i.e., can provide buprenorphine by prescription for office-based treatment of opioid use disorder) to treat up to 100 patients, with only 43 physicians treating more than 50 patients in one years’ time. Clearly, many prescribers do not operate at capacity.

It is estimated that there are over 20,000 individuals in RI with opioid use disorder not on MAT who could benefit from it. There is an opportunity to dramatically increase buprenorphine prescribing, in addition to continuing to expand methadone and injectable-naltrexone availability. The principles of treatment should include a comprehensive evaluation and initiation of the most appropriate treatment for that individual.

A key strategy in the Governor's Overdose Strategic plan is the development of Centers of Excellence. These specialized treatment centers can provide comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as support to providers in the community. It is envisioned that such Centers would refer stabilized patients to other providers and receive back patients if they destabilize and require more intensive services.

The State is seeking to implement Centers of Excellence for the treatment of Opioid Use Disorders. It is our intention to collaborate with the Executive Office of Health and Human Services (EOHHS) Medicaid Office and Medicaid Managed Care Organizations to ensure that the care coordination necessary to outreach and engage vulnerable populations, especially, the population with opioid use disorders, is effective and efficient. It is our hope that through the spirit of collaboration with Centers of Excellence and other delivery systems serving Medicaid beneficiaries, a system can be established that meets the needs of the State, the MCO's, and most importantly the individual.

II. PRINCIPLES OF DESIGN AND OPERATION

A. System for Purchase of Services: Expanded Services, Provider Certification

Certified COEs will be authorized to provide a set of enhanced treatment services to Medicaid beneficiaries who require MAT using buprenorphine or injectable naltrexone for opioid use disorders. These services will be reimbursed through Medicaid for beneficiaries who are deemed eligible for the services.

B. Centers of Excellence Providers

COE providers administer an identified set of services and supports as described in the Certification Standards developed for each direct services. All COE services are intended to support individuals in medication stabilization, elimination of illicit opioid use, elimination/reduction of illicit drug use, treatment retention and improved health outcomes.

C. Eligibility and Scope of Services

i. Eligibility for COE Services

COE services are established as Medicaid services which are eligible for reimbursement by the State for all Medicaid eligible beneficiaries diagnosed with opioid used disorder and appropriate for MAT. COEs are not limited to Medicaid reimbursement and may establish contracts with commercial insurers.

ii. Scope of Services

The Services included in COEs are intended to stabilize individuals on medication, provide intensive clinical support, promote recovery and referral to less intensive community based care. It is expected that the need for this intensive level of support should not exceed six (6) months and the enhanced rate for COEs is limited to that duration. If individuals are not successfully transferred to community providers within that timeframe, funding will revert to standard treatment rates. The Treatment Plan should be based on the needs and choices of the individual and updated as required by regulation. Level 1 providers will be able to admit all individuals within twenty-four (24) hours of referral and will receive an enhanced rate for induction as this will require physician availability seven (7) days per week. Level 2 providers will be required to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday.

D. Coordination and Collaboration with Other Parties

It is a fundamental requirement that COEs develop integrated relationships with health centers, physicians and other healthcare providers, community mental health providers and other programs such as permanent supportive housing providers, and community action programs. Development of relationships for referral purposes both to and from the COEs is crucial to the success of the program. While COEs may not be required to coordinate these systems they are expected to identify, facilitate access to, and support the attainment of other community services that may provide additional support or care for recovery. COEs are intended to meet gaps in the access to existing services and provide a bridge to less intensive community based treatment.

E. Other State and Local Public Agencies

There are several State and local agencies which may be actively involved in the life of the individual receiving COE services. These may include, but are not limited to: BHDDH, Executive Office of Health and Human Services (EOHHS), Department of Human Services (DHS), Division of Elderly Affairs in DHS, or the Department of Children, Youth and Families (DCYF). Each of these agencies function with a set of legal obligations and authorities, funding arrangements and limitations, and service capabilities. A current practice of integrating and coordinating systems of care intends to promote health outcomes and reduce duplication. It is expected that COE staff will work closely with these agencies to identify opportunities to meet the needs of each individual.

F. Statewide Capacity

COE providers may not limit access of participation by geographic or regional catchment area. It is expected that COEs will assist patients in accessing reliable transportation as needed.

G. Linguistic and Cultural Competency

The COEs must be able to demonstrate how they will provide services to persons whose primary language is not English. The providers must include in their policies and procedures how they will demonstrate cultural competency, person-centeredness and honor all individuality including race, religion, ethnicity, sexual orientation, and financial status.

III. CERTIFICATION PROCESS

A. Submission of Certification Application Required

To be eligible for reimbursement for COE Services, the provider must be certified by BHDDH as a COE.
Applications will be evaluated on the basis of written materials submitted to BHDDH. BHDDH reserves the right to conduct an on-site review and to request additional information or clarification prior to final scoring of any application. BHDDH reserves the right to limit the number of entities which may become certified as COEs.

Prior to submitting an application for certification, the applicant should fully review these Certification Standards and agree to comply with the requirements as outlined. BHDDH reserves the right to amend the Certification Standards with reasonable notice to participating certified providers and other interested parties.

B. Instructions and Notifications to Applicants

This document stipulates the Certification Standards for COE providers. Certified COEs shall comply with all performance requirements contained herein and as amended. These certification standards also serve as the application and Section V identifies standards against which applications will be scored. These are divided into six (6) core areas:

- Organizational Structure/ Philosophy
- Strength of Program Approach
- Organization of Service Delivery System
- Quality Assurance
- Organizational Capacity
- Data Collection and Reporting

Specific standards and expectations are identified within each of these six (6) areas, details for each are provided in Section V.

Upon receipt, applications will be reviewed for completeness and for compliance with core expectations and incomplete applications will be returned without further review.

All materials submitted to BHDDH for consideration in response to these Certification Standards are considered to be Public Records as defined in Title 38, Chapter 2 of the Rhode Island General Laws, without exception.

Completed applications should be directed to:

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Division of Behavioral Healthcare
14 Harrington Road
Cranston, RI 02920

The following certification outcomes are possible as a result of the application review process:

- **Certification with No Conditions:** The provider fully meets all Certification Standards.

- **Certification with Conditions:** An applicant may describe a program that meets most of the Certification Standards, but does not fully comply with the certification requirements at the time of the application submission. The applicant may be offered "Certification with Conditions" and requested to comply with the corrective action request by a specific date. Failure to comply fully with the correction action plan may result in loss of certification.

- **Not Certified:** The provider does not meet the requirements for certification.

Certification Period

BHDDH reserves the right to certify one (1) or more applicants. If areas of provider deficiency are identified, timely corrective action will be required. Certified Providers are required to notify BHDDH in the event of any material changes in their organizational structure or program operations. BHDDH will monitor the performance of certified providers to ensure continued compliance. BHDDH reserves the right to suspend or terminate certification.

IV. REQUIRED SCOPE OF SERVICES

A. Submission of Certification Application Required

COEs providers must be established to provide respectful, person-centered services. The organization must have the capacity to support all referrals to treatment. Individuals who receive

COE services may have chronic health conditions and be considered vulnerable. COE providers may not discriminate against individuals for any reason. It is assumed that COE providers will be a member of a multi-disciplinary team and required to collaborate but may not be responsible for care coordination.

B. Scope of Required Services

This section identifies the COE services that will be reimbursed by the State and the expectation for each service. Staff directly employed by providers who are part of the multidisciplinary team are eligible to provide these services. Additionally, certified providers must be able to conduct the full range of services herein. COEs provide rapid access to evidence based treatment for individuals with opioid use disorders using one (1) of the three (3) medications approved for this disorder – methadone, buprenorphine or injectable naltrexone. These services are designed to provide medication stability and symptom relief so that individuals can engage in clinical services to address behavioral changes necessary to support sustained recovery. The expectation for COEs is that once stabilized and the clinical intensity need is decreased, patients will be transferred to buprenorphine prescribers in the community.

COE services include: complete biopsychosocial assessments and physical exams; observed medication inductions; individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis.

C. Definition of Services

Complete Biopsychosocial assessments and physical examination. The process of the initial assessment and physical examination shall maximize opportunities for the clinician to gain an understanding of the person and for the person served to access the most appropriate services. A physical health assessment, including a medical history and physical examination, shall be completed within the first twenty-four (24) hours of a person's admission to the program. All persons served shall have a urine toxicology test upon admission. A specimen positive for opioids is not necessary for admission to a COE, if other criteria, such as the following, have been satisfied:

- Individual meets the DSM diagnostic requirements for opioid use disorder.
- Individual is clearly at risk for relapse while receiving services in an abstinence-based program.

Observed Medication Induction. A physician shall determine, and document in writing, the initial dose and schedule to be followed for each individual admitted to the COE. The initial dose and schedule for each person shall be communicated to the licensed medical staff supervising the dispensing of any opioid replacement treatment medication. The prescribed drugs shall only be administered and dispensed by licensed professionals authorized by law to do so. The following is a method of induction for buprenorphine/naloxone (based on a protocol available from PCSS-MAT):

1. Evaluate the level of opioid withdrawal with the COWS.

2. Wait until a COWS score of 7-10 is observed (see Nielsen et al. 2013).

3. Instruct the patient how to take the medication, under the tongue, no talking and swallow when fully dissolved.

4. Administer the first dose of 2/0.5-4/1 mg under observation in the office or inpatient setting.

5. Keep the patient in the office for at least an hour to determine the effect of the first dose, and then document the effect of the first doses in the medical record.

6. Depending on the amount and type of opioid use, the first day's dose may range from 2/0.5 to 8/2 mgs. Lower doses are required in patients with a lower level of physical dependence.

7. If the patient is not in withdrawal upon evaluation, they will need to be scheduled for induction on another day. Avoid this complication by taking the time make sure that the patient understands the need to be in moderate withdrawal prior to the first buprenorphine/naloxone dose.

8. If the individual in the office is pressing for relief and the doctor is still not certain that he is in sufficient withdrawal then a low dose of 2/0.5 mg can be given, the person observed for an hour and another dose of 2/0.5-4/1mg given if the first dose is well-tolerated.

9. Have the patient return the following day to complete the induction and provide the buprenorphine/naloxone dose (up to 16/4 mg) based on the person's report of response to the initial doses given on Day 1.

10. Provide a prescription for doses needed to get to the next appointment

Individualized Treatment Planning. Based on the biopsychosocial assessment, a goal-oriented**,** individualized treatment plan shall be developed and implemented with each person served. The process of clinical documentation shall maximize the active involvement of the person served and shall promote the individual's efforts toward recovery. There shall be evidence that the person's strengths and preferences, his or her needs, issues, challenges, and diagnoses are identified in the biopsychosocial assessment and are considered throughout the person's treatment.

Individual and Group Counseling. Counseling is a behavioral treatment to address the symptoms of addiction and related impaired functioning. Counseling is available for individuals, groups, couples or families. Counseling for substance use disorders is a time-limited approach focused on behavioral change that addresses mental health issues and teaches strategies and tools for recovery.

Randomized toxicology. Illicit drug use during treatment must be monitored continuously, as lapses during treatment do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

Coordination of Care with other treatment providers. Coordination of care involves the integration of health, behavioral health and social care services. Components of care coordination include:

(1) Working with an individual and his/her caregivers to ensure that a high-level, integrated and personalized care plan is implemented, (2) monitoring services to ensure they are delivered effectively on time and achieve their objectives, (3) facilitating communication between multiple agencies and professionals, and (4) maintaining contact with the individual during hospital stay and arranging for discharge.

Referral for services not provided at the COE or to higher levels of care. COEs must continually assess patients' mental status and needs related to substance use disorders. COEs must maintain capacity to refer to services not offered on-site through formal and informal relationships with providers of these services.

Case management to address other support service needs. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes

Wellness promotion activities. The provision of information and/or education to individuals, and families that make positive contributions to their health status. Health Promotion is also the promotion of healthy ideas and concepts to motivate individuals to adopt healthy behaviors.

Continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community. Once patients who are successfully discharged to

community based physicians who can prescribe buprenorphine/naloxone, COEs must offer and be able to provide continued outpatient clinical, case management and peer support services.

Consultation and support to community buprenorphine physicians. To support successful transfers to community based providers, COEs must offer consultative services to physicians in the community and offer expertise in the management of buprenorphine patients.

Discharge Planning. The process of discharge planning should begin at admission. COEs must establish discharge criteria for transfer to community based care. Each patient's treatment plan should clearly outline objectives leading to successful community discharge.

Readmission and re-stabilization of individuals who have relapsed or are experiencing crisis. COEs must work in collaboration with community providers to identify criteria for referral back to COEs from community providers and processes to facilitate readmission.

D. Transition and Discharge

COEs are designed to provide rapid access to MAT for individuals with opioid use disorders in need of intensive treatment services. Discharge planning is a collaborative process that is done with the individual, the COE staff, and any other relevant service providers. Individuals receiving COE services are to be informed of the intent and time-limited nature at the time the services commence. Discharge planning will be conducted with the involvement of all interested parties and must include an offer of continued clinical and/or recovery support services through the COE.

i. Discharge Criteria

An individual may be deemed ready for discharge if one of the following exists:

1) The individual voluntarily elects to terminate participation
2) The goals and objectives of the treatment plan have been met and a referral is coordinated to a willing community based physician.
3) The individual is not benefitting from the treatment and requires a higher level of care.

V. Certification Standards

A. The core areas for provider certification include:

i. Organizational Structure

a. A provider of COE services must be fully licensed and in compliance with the rules and regulations of the licensing Department (BHDDH or Health).
b. Potential conflicts of interest must be disclosed and an organizational chart must be provided at the time of application.
c. COEs must be accredited by one of the recognized accreditation bodies – The Joint Commission, CARF, or COA.

d. COEs must maintain compliance with all applicable state and federal statutes.
e. Staffing requirements for the multidisciplinary teams of COEs are as follows:
    - Data-waivered physicians
    - Nurses (registered and/or licensed practical nurses)
    - Master's Level Clinician (ratio no greater than 1:100)
    - A proposed combination of licensed chemical dependency professionals (LCDPs), case managers and/or peer recovery coaches. Applicant must discuss staffing in proposal and address relevancy to anticipated population as well as staff to patient ratios
    - COEs which are licensed Opioid Treatment Programs must also include a Pharmacist

ii. Strength of Program Approach COEs Must:

a. Demonstrate a positive relationship with community agencies.
b. Indicate how they promote evidence-based clinical services such as: Relapse Prevention Therapy, Motivational Interviewing, and Cognitive-Behavioral Therapy.
c. Maintain a person-centered approach that includes: Participant involvement in program evaluation; participant involvement in goal planning; Flexibility in programs and service delivery to meet participant needs. COEs will be evaluated on their ability to retain patients until such time as they can be safely transferred to care in the community. COEs are voluntary and consumer-driven.
d. Offer 24-hour emergency telephone coverage and triage.
e. Level 1 COEs must be able to admit patients within twenty-four (24) hours of initial contact.
f. Level 2 COEs must be able to admit patients within forty-eight (48) hours of initial contact Saturday – Thursday, and within seventy-two (72) hours on Friday.
g. Demonstrate capacity to use health information technology.
h. Establish and maintain connection to Office Based Opioid Treatment (OBOT) providers in a provider network, clear policy and procedures shall be established for communication with other health professionals
i. Establish a provider network for referral to services not provided at the center such as psychiatric treatment and residential.
j. Establish clear process for referral back to COE from Office Based Opioid Treatment (OBOT) providers as well as providing consultation services for OBOTs.
k. Provide education/internship opportunities for healthcare professionals, residents, and/or students.
l. Agree to participate in any related Learning Collaborative.
m. Establish a process for receiving and accepting relevant information to coordinate care for participants among the OTP and primary and specialty care providers, including mental health treatment providers. This may include development of data sharing system that includes Electronic Medical Record (EMR) expansion, use of Direct

Messaging through the State's Health Information Exchange to help safeguard privacy of this information and assure compliance with all related state and federal confidentiality regulations

n. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members, and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate
o. Establish Quality Service Organization Agreements and/or Memorandums of Understanding with agencies/facilities providing higher levels of care.

iii. Organization of Service Delivery System

a. Providers must have a sound organizational approach with clear structure that includes required credentials for each position, job descriptions, and communication guidelines.

b. Providers must have established standards for team meetings, case conferences, intake, assessment, staff supervision and evaluation, and guidelines for inter and intra agency collaboration.

c. COEs must offer the following services for each patient:

- Comprehensive Assessments and treatment recommendations such as differential diagnosis, assessment of need for medication assisted treatment versus other services, use of methadone or buprenorphine. Assessments must comply with standards set forth by licensing and/or accreditation bodies.
- Complete physical examinations prior to induction of medication.
- Check Department of Health's Prescription Monitoring Program for each new admission and quarterly thereafter.
- Induction and stabilization services for initiation of buprenorphine or injectable naltrexone. Centers must document that patients have received education on all forms of treatment available for opioid use disorder and an Informed Consent form must be maintained in the patient record.
- Treatment planning in accordance with relevant licensing regulations and accreditation guidelines. Treatment plans are to be person-centered, identifying long and short term goals, objectives and the individual responsible for identified interventions. Treatment plans must be updated in response to significant changes in condition.
- Individual and group counseling with frequency, duration and modality specified to meet the needs of the patient as identified in the Treatment Plan. Group counseling shall be facilitated by the Master's Level Clinician.

- Randomized toxicology – minimum of 2x monthly for first three (3) months, decreased to minimum of 1x monthly for last three (3) months. Toxicology results shall be used as a tool in the provision of treatment services and identifying required levels of care and service intensity. Toxicology results alone shall never be used as a cause for discharge.
- Support and consultation for recovery and rehabilitation services assistance with regard to treatment needs in designing individualized recovery plans and coordination with human services, housing, employment, and other specialized services and supports.
- Re-assessment and treatment recommendations for patients successfully transferred to community providers who subsequently experience a relapse.
- Provision of two out of three medications to treat opioid dependence (methadone, buprenorphine, injectable naltrexone).
- Medication dispensing and/or prescribing with capacity for observed dosing and at a frequency established by the Medical Director and approved by BHDDH.
- Comprehensive patient and family education programs. Programs including group sessions to educate about Opioid Use Disorder and to encourage dialogue amongst affected families.
- Wellness promotion activities.
- Continued outpatient counseling, care coordination, case management and/or peer recovery services for interested patients who have transferred to OBOTs.
- Re-admission and re-stabilization of patients in community who have experienced relapse or other crises.
- Discharge planning and referral based on established criteria.
- Care coordination and consultation with primary, specialty care and hospital services.

iv. Quality Assurance

a. COEs are required to have policies, procedures, and activities for quality review and improvement acceptable to the State that is updated on an annual basis. The plan should include implementation timelines for plan objectives.

b. Providers must include the following components in the policies and procedures for quality review:

Audit of client records for completeness and accuracy; Degree to which services in Treatment Plan are provided; methods of evaluating staff performance; Degree of coordination with other systems; Identification of internal processes related to timeliness of admissions and caseload standards for personnel.

c. COEs must maintain a complete patient record which complies with established clinical documentation requirements of licensing and accreditation bodies and adheres to the most current standards of confidentiality for each participant.

d. Providers must comply with the most current Federal and State laws pertaining to privacy and security of all Personal Health Information (PHI), including client records. All COEs shall be considered "Part II" providers and are bound by Federal Confidentiality laws found in 42 CFR Part II.

e. COEs must ensure that staff meet all requirements for their respective positions. Current records shall be maintained document compliance, including continuing education requirements.

f. Providers must have written policies and procedures for ensuring safety in the care environment for both staff and program participants.

g. Providers must have written policies and procedures to inform participants and staff of their rights and the process to seek redress of grievances and appeals.

h. COEs must have a process for data collection for quality indicators. The performance measures include:

- Utilization – the number of individuals admitted receiving Medication Assisted Treatment
- Rate of successful discharge to community based providers (OBOTs) – baseline established is 33% within 6 months. COEs will be evaluated on how well they meet or exceed this target
- Reduction of illicit opioid use as measured by percentage of negative toxicology screens
- Reduction of all other illicit substance use as measured by percentage of negative toxicology screens
- Reduction in the use of Emergency Departments using previous year use as a baseline
- Reduction in hospitalizations using previous year use as a baseline
- Engagement and retention rates as measured by percentage of patients who remain in treatment with COEs until successful community referral

v. Organizational Capability

a. Providers must be able to perform the operational functions necessary for overseeing a direct-service program. This includes an efficient billing system and encounter documentation coordinated across multiple sites, if necessary.

b. Providers must demonstrate sound financial management operations that include: timely billing; internal calculations for services generated by program and type, revenue distribution, and payment tracking against claims; methods for determining future cash requirements and ensuring adequate cash flow; risk management arrangements with specific attention to general, professional, and director/officer liability; policies and procedures in third party liability and coordination of benefits in relation to Medicaid.

c. Providers must furnish a copy of its most recent full independent financial audit. Audit may be no more than eighteen (18) months old.

d. Providers that are first time recipients of Medicaid reimbursement or EOHHS funding must provide a sound business plan with plans for development and projected monthly revenue and expense statement for twelve (12) months. The plan must include the following: definition of assumed consumer base, services, revenues, and expenses; outline management of initial expenses; and program development and enhancement timelines.

vi. Data Collection and Reporting

Providers must maintain a BHDDH approved data collection and reporting system, coordinated across multiple sites, if necessary.

Appendix

I. Application Guide

1. Overview

This application guide provides information and instructions regarding the submission process and the review of applications, providing guidance for applicants in the development and submission of a complete application.

2. Application Submission and Review

Applications will be reviewed on the basis of written materials and other pertinent information submitted to BHDDH. BHDDH reserves the right to conduct and on-site

review and to otherwise seek additional clarifications from the applicant prior to final scoring of the applications. BHDDH reserves the right to limit the number of entities which may become certified as COEs.

The applicant will have the opportunity to fully review these Certification Standards and agree to comply with the requirements as outlined. BHDDH reserves the right to amend the Certification Standards with reasonable notice to participating providers and other interested parties.

Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to BHDDH for consideration in response to these Certification Standards will be considered to be Public Records as defined in Title 38, Chapter 2 of the Rhode Island General Laws, without exception.

Inquiries and completed applications should be directed to:

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Division of Behavioral Healthcare
14 Harrington Road
Cranston, RI 02920

BHDDH will convene a COE Review Committee to evaluate applications. A periodic review process will be established by BHDDH.

The following certification outcomes are possible as a result of the application review process:

- **Certification with No Conditions:** The provider fully meets all Certification Standards.

- **Certification with Conditions:** An applicant may describe a program that meets most of the Certification Standards, but does not fully comply with the certification requirements at the time of the application submission. The applicant may be offered "Certification with Conditions" and requested to comply with the corrective action request by a specific date. Failure to comply fully with the correction action plan may result in loss of certification.

- **Not Certified:** The provider does not meet the requirements for certification.

In order to be certified as a COE it is necessary to meet the performance requirements and standards as detailed in this document. Once a provider is certified the provider will be enrolled with HP as a provider of COE Services.